

Authorization Form for Information Release

You may authorize your insurer in writing to share your health information with a third party such as an employer, lawyer, individual broker or unrelated party by completing and submitting this authorization.

Please print neatly to ensure correct and prompt processing. We reserve the right to return any illegible or incomplete form.

1.) I hereby Authorize: _____
(Prescription Drug Plan/Company)

2.) To release information from the records of:
(Complete a separate form for each member)

Name: _____ Date of Birth: _____

Membership Number: _____

Address: _____

Home Phone: _____ Work Phone: _____

3.) Information authorization for release:
(Check all that apply)

Claims/EOB Information Enrollment & Benefit information

Information pertaining to an appeal Premium Payment information

Other: _____
(Please specify date of service and/or third party)

4.) Information may be released to:

A. Name of individual: _____

Address: _____

City, State, Zip: _____ Telephone: _____

B. Name of individual: _____

Address: _____

City, State, Zip: _____ Telephone: _____

5.) The information will be used or disclosed for the following purposes: (Describe the reason for each use and disclosure of the protected health information or indicate “at the request of the individual”)

Please read each of the following statements carefully before signing this document.

- 1.) I understand that **this authorization will stay in effect unless revoked.**
- 2.) I understand that this authorization voluntary and being made at my request.
- 3.) I understand that the released information may no longer be protected by federal privacy laws and may be re-disclosed by the individual or organization that receives the information.
- 4.) I understand that I may refuse to sign this authorization. My Prescription Drug Plan will not condition payment, enrollment, or eligibility of benefits on my signing this authorization.
- 5.) I understand that I may revoke this authorization at any time by sending a written notification to Medi-CareFirst at the address listed below, and this revocation will be effective for future uses and disclosures of protected health information. However, I further understand that this revocation will not be effective: (i) for information that my Prescription Drug Plan has already used or disclosed, relying on this authorization, or (ii) if the authorization was obtained as a condition for coverage in my Prescription Drug Plan and, by law, the Prescription Drug Plan has a right to contest the coverage.

SECTION I: APPOINTMENT OF REPRESENTATIVE

To be completed by the party seeking representation (i.e., the Medicare beneficiary, the provider or the supplier)

I appoint this individual: _____ to act as my representative in connection with my claim or asserted right under title XVIII of the Social Security act (the “act”) and related provisions of title XI of the act. I authorize this individual to make any request; to present or to elicit evidence; to obtain appeals information; and to receive any notice in connection with my appeal, wholly in my stead. I understand that personal medical information related to my appeal may be disclosed to the representative indicated below.

Signature of Party Seeking Representation: _____ **Date:** _____

Street Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone Number (with Area Code): _____

SECTION II: ACCEPTANCE OF APPOINTMENT

To be completed by the representative:

I am a /an _____ (Professional Status or relationship to the Party, e.g. attorney, relative, etc.)

I, _____, hereby accept the above appointment. I certify that I have not been disqualified, suspended, or prohibited from practice before the department of Health and Human Services; that I am not, as a current or former employee of the United States, disqualified from acting as the party's representative; and that I recognize that any fee may be subject to review and approval by the Secretary.

Signature of Representative: _____ **Date:** _____

Street Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone Number (with Area Code): _____

If you need help completing this form, please call Medi-CareFirst toll-free at Membership Customer Service at 1 (888) 857-6118, (October 15 to February 14): 8 a.m. to 8 p.m., 7 days a week; (February 15 to October 14): 8 a.m. to 8 p.m., Monday through Saturday. TTY users should call 1 (800) 855-2880.

Please mail or fax this authorization to:

**Medi-CareFirst BlueCross BlueShield, Membership Customer Service
c/o CGI, Inc., P.O. Box 2668, Fort Worth, TX 76113
Fax: 1-888-524-6787**

Please keep a copy of the designation. We will provide you with a signed copy of this designation upon request.

If the records are so protected, Federal Regulation (42 CFR Part 2) prohibits the recipient of the information from making any further disclosure of this information unless such disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Medi-CareFirst BlueCross BlueShield is the business name of Group Hospitalization and Medical Services, Inc. and First Care, Inc., and each is an independent licensee of the Blue Cross and Blue Shield Association. ® Registered trademark of the Blue Cross and Blue Shield Association. ®' Registered trademark of CareFirst of Maryland, Inc.